APPLICATION FOR FAMILY MEDICAL LEAVE

Employee Name _____

Social Security Number _____

Agency Name _____

Agency Address _____
_____

Regular Hours worked Per Week _____

Home Address _____
_____

Home Phone (____) _____ Work Phone (____)_____

Purpose of Family Leave_____
_____
_____

Attach REQUIRED supporting documentation
Anticipated duration of leave from _____ to _____ for a total of _____ work days. In requesting family leave, I certify that all information on this application is true and that I will abide by the regulations governing family leave.

_____ _____
Employee Signature Date

FOR AGENCY USE ONLY:
Family Leave Approved _____
For Dates _____ to _____
Family Leave Denied _____
Family Leave Balance as of this date _____
Family Leave Designation Letter sent _____
Date

_____ _____
Signature of Appointing Authority or Designee Date

Revised: Mar/2009